Louisiana Early Hearing Detection and Intervention Program

Physician Follow-up Services Report
Children Birth – 3 years

Louisiana Department of Health and Hospitals | Office of Public Health
Early Hearing Detection and Intervention (**EHDI**) Program

www.ehdi.dhh.la.gov

Fax within **7 days of appointment** to
FAX# (504) 568-5854

Child's Last Name (on birth certificate)	**Child's First Name (on birth certificate)**	**Middle Initial**	**Child's DOB**

Mother's Last Name	**Mother's First Name**	**Mother's Maiden Name**

Address	**City**	**State**	**Zip Code**

Phone Number	**Alternate Phone Number**	**Parent Email**
( )	( )	

Hospital of Birth

Facility Name _____ **Physician Name** _____

City _____ **State** ____ **Zip** _____ **Ph # (____)**_____ **Fax # (____)**_____

Are you the Primary Care Provider for this patient? ☐ **YES** ☐ **NO**

If NO: PCP Name _____ **City**_____

☐ **Patient Lost to Follow-up for YOUR Facility** *(check all that apply)* **Date Reported:** _____

- ☐ Missed Appointment(s)
- ☐ Cannot Contact: *(if "Cannot Contact", required to select at least 1 reason)*
  Phone: ○ Disconnected ○ No answer ○ No response to voice message Letter Mailed: ○ Returned ○ No response
- ☐ Other Physician Re-screened: Who? _____ City: _____
- ☐ Moved Out of State: Where? _____ ☐ Other – Explain: _____

Date of Today's Appointment: _____ **Person Testing:** _____

Reason for hearing screening: *(choose only 1)*

- ☐ Initial Hearing Test (no newborn hearing screening was performed at birth)
- ☐ Follow-up Re-screening (infant failed **hospital** newborn hearing screening)
- ☐ Parent or Physician Concern

Type of hearing screening performed:

- ☐ OAE – Otoacoustic Emissions
- ☐ ABR – Auditory Brainstem Evoked Response (also sometimes named "BAER")

OAE		**ABR / BAER**	
Left	**Right**	**Left**	**Right**
○ Passed	○ Passed	○ Passed	○ Passed
○ Did NOT Pass	○ Did NOT Pass	○ Did NOT Pass	○ Did NOT Pass
○ Could not test	○ Could not test	○ Could not test	○ Could not test

- **BOTH** ears must be tested, even if infant initially failed only 1 ear in hospital.**
- If infant **failed ABR** screening in hospital, **re-screening** should be **with ABR.****
- If the child did not pass this hearing screening, an appointment with an **audiologist** should be scheduled **immediately** for further diagnostic testing.**

***Source: Joint Commission on Infant Hearing –JCIH 2007 Position Statement / AAP Policy Statement*

Please indicate any referrals you have made:

☐ Audiologist: Who? _____ Appointment Date _____

☐ Otolaryngologist: Who? _____ City _____

Comments: _____